

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/05/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLARK MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MISSOURI AVE JEFFERSONVILLE, IN 47130</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00100914 Substantiated: No deficiencies related to allegations are cited.</p> <p>Date of survey: 3/5/12</p> <p>Facility number: 005009</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Clark Memorial Hospital is in compliance with 410 IAC 15-1.5-8, Physical environment, 410 IAC 15-1.6-2, Emergency services and 410 IAC 15-1.5-2, Infection control, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/16/12</p>	S 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

6MYU11

If continuation sheet 1 of 1